No. 94-22

(15)

IN THE
Supreme Court of the United States
OCTOBER TERM, 1994

CITY OF EDMONDS,
Petitioner,
v.
WASHINGTON STATE BUILDING CODE COUNCIL
and UNITED STATES OF AMERICA,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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AMICUS CURIAE BRIEF OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS IN SUPPORT OF RESPONDENTS

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STATEMENT OF INTEREST OF AMICUS CURIAE

The American Association of Retired Persons ("AARP") is a not-for-profit membership organization of more than thirty-three million persons aged 50 and older. In representing the interests of its members, AARP seeks to (a) enhance the quality of life for older persons; (b) promote independence, dignity, and purpose for older persons; (c) advance the role and place of older persons in society; (d) sponsor research on physical, psychological, social, economic, and other aspects of aging; and (e) support the expansion of quality, well-managed and accessible housing options for older persons.

AARP's membership includes many older persons with disabilities, and the Association supports their right to equal choice in housing. Accordingly, the Association advocated for the provisions of the Fair Housing Amendments Act of 1988 extending equal housing opportunities to persons with disabilities and prohibiting unreasonable exclusionary local land-use laws and ordinances.

Exclusionary zoning and land-use laws often limit housing opportunities for older persons with disabilities.[1] This case involves the application of a zoning ordinance to a group home for persons with disabilities related to previous alcohol and drug dependencies, but the legal principles established will likewise affect group living arrangements for older persons with a range of other disabilities.

The threat of exclusion from community life because of unreasonable zoning restrictions is real to the many older Americans now living in non-institutional group settings. Although the overwhelming majority of older persons want to live independently, either by themselves, with family, or with assistance from professional caretakers provided in their homes, health or financial problems sometimes force them into other arrangements.

A wide variety of group living arrangements exists for older persons with disabilities. A growing number of such people live in group living arrangements sometimes referred to as board and care homes. These homes provide

[1] *See, e.g., Casa Marie, Inc. v. Superior Court of P.R.*, 752 F. Supp. 1152 (D.P.R. 1990), *vacated*, 988 F.2d 252 (1st Cir. 1993) (zoning ordinance and restrictive covenant used to challenge facility for older mostly handicapped persons); *Potomac Group Home Corp. v. Montgomery County, Md.*, 823 F. Supp. 1285 (D. Md. 1993) (elderly group home residents with Alzheimer's disease threatened with eviction because of group home provider's failure to give neighbors notification as required by county licensure law); *United States v. City of Taylor*, 798 F. Supp. 442 (E.D. Mich. 1992), *rev'd sub nom., Smith & Lee Assocs., Inc. v. City of Taylor, Mich.*, 13 F.3d 920 (6th Cir. 1993) (city ordinance defined family to exclude elderly and disabled residents of a group home).

shelter, food, personal care, and 24-hour protective oversight in single-family dwellings in residential neighborhoods. The identical living arrangement is sometimes referred to by many other names, e.g., assisted living facilities.[2] In order to simplify the discussion, this brief uses the term board and care home.

AARP acknowledges the right of state and local governments to restrict land use, so long as the restrictions do not result in unlawful discrimination. In some cases, though, even facially neutral land-use restrictions result in discriminatory treatment. Older persons have too large a stake in preserving equal access to housing to let such restrictions go unchallenged. AARP submits this brief as *amicus curiae* to inform the Court of a dimension to this case not immediately apparent from the facts—the large, and growing, numbers of older persons with disabilities who are no longer able to live independently and their need for a variety of housing options.[3]

STATEMENT OF THE CASE

AARP adopts the Respondents' Oxford House, Inc. et al. statement of the case.

[2] A recent survey found that states license board and care homes under more than 25 different names. Catherine Hawes et al., *The Regulation of Board and Care Homes: Results of A Survey in the 50 States and the District of Columbia* i (1993). Some common names are domiciliary care homes, personal care homes, community residence facilities, group homes, assisted living facilities, adult foster care homes, and residential care facilities. *See, e.g., Wolford by Mackey v. Lewis*, 860 F. Supp. 1123, 1126 n.2 (S.D. W. Va. 1994) for a description of one state's regulation of "residential board and care" and "personal care homes." Use of these terms varies not only from state to state, but also within a state and by the nature of the client population served. Vincent Mor et al., *A National Study of Residential Care for the Aged*, 26 Gerontologist 405, 405 (1986).

[3] The written consents of the parties have been filed with the Clerk of the Court pursuant to Sup. Ct. R. 37.3.

SUMMARY OF THE ARGUMENT

A broad construction of the Fair Housing Amendments Act (FHAA) requires a narrow interpretation of the exemption for maximum occupancy rules. Such a reading is necessary to effectuate the purposes of the FHAA. It also is sound policy to limit unreasonably restrictive zoning ordinances because a continuum of housing options is necessary to fulfill the financial and social needs of board and care residents. Board and care homes are best defined by the functions they perform, i.e., providing room, board, personal care, and protective oversight on a 24-hour basis to four or more unrelated adults. Board and care home residents have disabilities that necessitate assistance with the activities of daily living and taking medications.

Although estimates vary, more than a million persons live in board and care homes. At least half of board and care residents have private sources of income and the other half are publicly funded through the Supplemental Security Income (SSI) program. Board and care is a growth industry because of its low cost and the growing number of older persons with disabilities. Board and care residents are handicapped persons for purposes of the Fair Housing Amendments Act, and the growing number of older persons with disabilities and their need for residential community-based arrangements should inform the Court's interpretation of the FHAA's exemptions. Projected population trends show just how great the need will be for non-institutional group living arrangements.

ARGUMENT

I. INTRODUCTION.

The Fair Housing Amendments Act (FHAA) prohibits discrimination against handicapped persons in housing practices. 42 U.S.C. §§ 3604(f)(1), (f)(3)(B) (1988).[4] The FHAA also contains an exemption that provides: "Nothing in this subchapter limits the applicability of any reasonable local, State, or Federal restrictions regarding the maximum number of occupants permitted to occupy a dwelling . . . ." 42 U.S.C. § 3607(b)(1) (1988).

The Oxford House is located in Edmonds, Washington, and is a group home for six or more persons recovering from drug and alcohol dependencies. The residents qualify as handicapped persons by virtue of their participation in a supervised drug rehabilitation program, coupled with their non-use of drugs and alcohol. *City of Edmonds v. Washington State Bldg. Council*, 18 F.3d 802, 804 (9th Cir. 1994). Oxford House is located in a neighborhood zoned for single family dwellings, Edmonds Community Development Code § 16.20.000 et seq., and these dwellings are the only permitted primary uses. *Id.* at § 16.20.010 (A)(1). "Family means an individual or two or more persons related by genetics, adoption, or marriage, or a group of five or fewer persons who are not related by genetics, adoption or marriage. . . ." *Id.* at § 21.30.010. If the Code proscription against more than five unrelated persons living together qualifies as a maximum occupancy limitation, Oxford House cannot locate in an area zoned for single family dwellings in Edmonds.

AARP agrees with the legal arguments of the United States and other Respondents that the City of Edmonds' ordinance does not qualify for the Fair Housing Amend-

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[4] The terms handicapped persons and persons with disabilities are used synonymously in this brief, as they are in federal statutes. Compare the use of the term handicap in the FHAA definitions at 42 U.S.C. § 3602(h) (1988) with the term disability in the Americans with Disabilities Act at 42 U.S.C. § 12102 (Supp. V 1993).

ments Act exemption as a maximum occupancy limitation, and that this Court should uphold the Ninth Circuit's decision in *City of Edmonds v. Washington State Bldg. Council*, 18 F.3d 802 (9th Cir. 1994), rather than the decision in *Elliott v. City of Athens*, 960 F.2d 975 (11th Cir. 1992).

AARP will emphasize that the remedial purposes of the FHAA require a narrow interpretation of the occupancy limitation exemption; that group homes play a vital role in the continuum of housing for older persons with disabilities; and that stifling the growth of group homes is unwise because of projected increases in the numbers of older persons with disabilities.

II. THE REMEDIAL PURPOSES OF THE FHAA AND SOUND PUBLIC POLICY REQUIRE A BROAD INTERPRETATION OF THE PROTECTIONS PROVIDED AND A NARROW CONSTRUCTION OF THE MAXIMUM OCCUPANCY LIMITATION EXEMPTION.

Discriminatory housing practices such as the exclusionary zoning ordinance in this case prompted Congress to pass the Fair Housing Amendments Act of 1988. One purpose of the FHAA was to extend the principle of equal housing opportunity to handicapped persons because "like the other classes protected by title VIII [handicapped persons] have been the victims of unfair and discriminatory housing practices." H.R. Rep. No. 100-711, 100th Cong., 2d Sess. 13 (1988), *reprinted in* 1988 U.S.C.C.A.N. 2173, 2174. Congress expressly recognized that exclusion from equal housing opportunity is a by-product of stereotyping persons with disabilities. "The Fair Housing Amendments Act, like Section 504 of the Rehabilitation Act of 1973 . . . is a clear pronouncement of a national commitment to end the unnecessary exclusion of persons with handicaps from the American mainstream. . . . Generalized perceptions about disabilities and unfounded speculations

about threats to safety are specifically rejected as grounds to justify exclusion." *Id.* at 18; 1988 U.S.C.C.A.N. at 2179. Congress also recognized that land-use regulations have been used to discriminate against persons with disabilities and the Fair Housing Amendments Act was designed to end those practices.

The FHAA was enacted to protect against the very type of ordinance Edmonds has adopted—rules that single out subgroups to be regulated under the guise of health and safety. The House Judiciary Committee Report expresses this best:

> While state and local governments have authority to protect safety and health . . . that authority has sometimes been used to restrict the ability of individuals with handicaps to live in communities. (citation omitted) This has been accomplished by such means as the enactment or imposition of health, safety or land-use requirements on congregate living arrangements among non-related persons with disabilities. Since these requirements are not imposed on families . . . these requirements have the effect of discriminating against persons with disabilities.

Id. at 24; 1988 U.S.C.C.A.N. at 2185.

As a remedial statute, the FHAA's provisions should be afforded a broad construction. *Trafficante v. Metropolitan Life Ins. Co.*, 409 U.S. 205, 212 (1972). A broad construction of the FHAA requires that the exemptions from the protections contained in the statute be construed narrowly to effectuate the statute's general purposes. *United States v. Columbus Country Club*, 915 F.2d 877, 883 (3d Cir. 1990), *cert. denied*, 501 U.S. 1205 (1991); *City of Edmonds*, 18 F.3d at 804; *Elliott*, 960 F.2d at 978-79; *Massaro v. Mainlands Section 1 & 2 Civic Ass'n*, 3 F.3d 1472, 1475-76 (11th Cir. 1993). Narrowly construed, the Edmonds ordinance is not an occupancy limitation at all because the ordinance re-

stricts use rather than occupancy and does not apply equally to related as well as unrelated persons.

Moreover, an expansive construction of the exemption leads to an anomalous result—by adopting restrictive zoning ordinances, communities can effectively deny persons with disabilities, including older persons with disabilities, equal access to housing. Congress, however, intended precisely the opposite. The FHAA stemmed from a history of unequal housing opportunity and, therefore, when, Congress carved out exemptions from the statute's coverage, it sanctioned only those ordinances which reasonably restrict occupancy; it did not create a loophole of the magnitude authorized by *Elliott*. *Elliott* is based, in part, on the idea that if the exemption applies equally to related and non-related persons, the exemption has little meaning. Unfortunately, however, if the broad exemption recognized by the *Elliott* court and the district court below is upheld, it is the FHAA's sweeping prohibition of discrimination against persons with disabilities in housing which is rendered ineffectual.

A. Board And Care Homes Provide Much-Needed Residential Services To Older Persons With A Range Of Disabilities.

Board and care homes are best defined by function: "provid[ing] room, board, personal care, and protective oversight on a 24-hour basis to four or more adults . . . who were not related to the facility operator." Nancy D. Dittmar, *Facility and Resident Characteristics of Board and Care homes for the Elderly, in Preserving Independence, Supporting Needs: The Role of Board and Care Homes* at 1, 2 (Marilyn Moon et al. eds., 1987); *see also* Chandra M.N. Mehrotra & Karl Kosloski, *Foster Care for Older Adults: Issues and Evaluations,* 12 Home Health Care Servs. Q. 115, 115-16 (1991); Hawes et al., *supra* note 2, at 3. Board and care homes encompass diverse living environments, but all "seek to serve the

nonmedical needs of residents who, because of their disabilities, cannot function independently." Alexander Chen, *The Cost of Operation in Board and Care Homes, in Preserving Independence, Supporting Needs: The Role of Board and Care Homes, supra,* at 61, 61.

Residents of board and care homes vary greatly, but older persons with disabilities constitute a substantial portion of the population of such homes.[5] "[The] homes serve a very mixed group of residents, differentiated by a variety of characteristics, including age, types of impairments, and income level. Residents include people whose major reasons for being in a board and care home are age and physical frailty, often combined with a dearth of resources (monetary and familial)." Hawes et al., *supra* note 2, at 3. One researcher, after reviewing the board and care literature, concluded that "the typical elderly resident is a 70-year-old white female who has lived in the home for about three years and has never been married or is currently widowed." Sandra Newman, *The Bounds of Success: What is Quality in Board and Care Homes?, in Preserving Independence, Supporting Needs, supra,* at 109, 112.

The board and care population comes from the 4.4 million people aged 65 and older who experience difficulties in one or more activities of daily living. U.S. Senate Special Comm. on Aging et al., *Aging America: Trends and Projections* 144 (1991 ed.). Activities of daily living (ADLs) include bathing, ambulating, toileting, eating, dressing, and grooming. Mary Jane Koren, *Site-Specific Care, in The Merck Manual of Geriatrics* 199, 211 (William B. Abrams, M.D. & Robert Berkow,

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[5] The House Subcommittee identified the major populations as older persons who used to reside in old age or rest homes and deinstitutionalized persons with mental illnesses. Chairman, Subcomm. on Health and Long-Term Care, House Select Comm. on Aging, 101st Cong., 1st Sess. *Board and Care Homes in America: A National Tragedy* 2-3 (Comm. Print 1989).

M.D. eds., 1990). About 17.5 percent of persons 65 and older have deficits in instrumental activities of daily living (IADLs), activities such as shopping, cleaning, managing finances, and using the telephone. *Id.* at 153. The needs for assistance with ADLs, IADLs, and with taking medication, are the primary non-economic predicates for group home care. An estimated one million of these older persons with disabilities [6] and other persons with disabilities live in board and care homes. *Board and Care Homes in America: A National Tragedy, supra,* at 9.[7]

B. Board And Care Homes Are A Vital Component Of The Continuum Of Care Necessary To Meet The Needs Of Older Persons With Disabilities.

The care needs of older persons with disabilities are increasingly diverse. A study of housing barriers faced by older women noted that mental and physical impairments, themselves, exist on a continuum depending on the nature and extent of the condition and the person's age. Bonnie Sether Hasler, *Barriers to Living Independently for Older Women with Disabilities: Housing* 19-21 (Patricia Forsythe & Laurel Beedon eds., 1991). As a consequence, needs vary from treatment and rehabilitation, to maintenance of the individual's highest possible quality of life, to reducing the effects of the disability. Providers must offer the services most appropriate for each client. *Id.*

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[6] Older persons with ADL problems sometimes are referred to as the "frail elderly," particularly in research literature.

[7] As with all housing options, the quality of board and care homes varies. The House Subcommittee focused on board and care homes serving the poorest residents and found many problems. *Board and Care Homes in America: A National Tragedy, supra, passim.* Other observers of the same types of homes have not described the homes so negatively. *See* Dittmar, *supra,* at 3; Hawes et al., *supra* note 2, at 76.

Preservation and enlargement of available housing choices promote a better match between clients and the type of care they receive and will have a positive impact on the quality of life of older adults. The range of housing options for older persons extends from simple shelter for the most independent to skilled nursing facilities that provide a nearly total life support system for the frailest of older persons. Arthur E. Gimmy & Michael G. Boehm, *Elderly Housing: A Guide to Appraisal, Market Analysis, Development and Financing* 19 (1988). Board and care falls between the extremes of independent living and the total care environment of an institution.

A continuum of care permits the frequency and intensity of necessary care to dictate which option is most appropriate for each individual.[8] This continuum enables older persons to live in the "least restrictive environment with the greatest amount of privacy for as long as possible. Loss of independence need not lead to permanent loss of self-esteem or loss of power to exercise competent choices and decisions in one's own life." Medical Care and Research Foundation, *Proving New Directions, New Hope in Board and Care: Practical Guidelines for Establishing and Operating Small Assisted Living Facilities for the Elderly* 3 (1988).

Board and care contributes a vital component on the continuum of care available to both older and younger persons with disabilities. One of the attractive features of board and care is that residents are able to benefit from more home-like settings in residential neighborhoods. Rosalie A. Kane et al., *Adult Foster Care for the Elderly in Oregon: A Mainstream Alternative to Nursing Homes?,* 81 Am. J. Pub. Health 1113, 1113 (1991). Group homes provide older persons with "the opportunity to live in home-like milieus instead of . . . more institutionalized

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[8] The term continuum of care is commonly used to describe the concept of matching services to needs. *See, e.g.,* Terrie Wetle, *Social Issues,* in *The Merck Manual of Geriatrics, supra,* at 1127, 1129-32.

nursing homes" and prevent "premature institutionalization." *Potomac Group Home Corp. v. Montgomery County, Md.*, 823 F. Supp. at 1289. Some clients require the socially-oriented care setting of community residence for health reasons. Others simply prefer to obtain needed services in that setting. Kane, *supra,* at 1117-19.

Older persons with Alzheimer's disease illustrate the need for board and care type settings. According to the Alzheimer's Disease and Related Disorders Association (ADRDA), more than four million Americans have Alzheimer's disease. Alzheimer's Disease and Related Disorders Association Inc., Alzheimer's Disease Statistics [ADRDA Factsheet] (1993) (On file at AARP). Nearly 10 percent of this country's population over age 65 has Alzheimer's disease. *Id.*

Alzheimer's disease is a progressive, degenerative disease that attacks the brain and results in impaired memory, thinking, and behavior. The person with Alzheimer's disease may experience confusion, changes in personality and behavior, impaired judgment, and difficulty finding words, finishing thoughts, or following even simple directions. In short, the disease causes precisely the types of impairments which produce the need for assistance with activities of daily living.

Life expectancy from the onset of Alzheimer's symptoms varies from three to more than twenty years, but the individual variations are striking. The decline may be quick, with the full range of cognitive deterioration occurring in one year, or the person may plateau at a level of impairment for several years. Robert Katzman & J. Edward Jackson, *Alzheimer's Disease: Basic and Clinical Advances,* 39 J. Am. Geriatrics Soc'y 516, 520 (1991). In any case, the housing needs for persons with Alzheimer's disease correlate to their degree of dementia. Many physically healthy persons with Alzheimer's disease or related dementias can live nicely in a community setting with assistance and supervision, at least during the early

and middle stages of the disease. In the later stages, when total care is needed, a nursing home looms as the only alternative.

As the Alzheimer's example illustrates, board and care kinds of settings will not replace nursing home care, but will contribute a vital component on the continuum of care necessary to meet the needs of older persons. Yet these much-needed group homes for all kinds of persons with disabilities will not be available if local jurisdictions can limit occupancy to small numbers of unrelated persons like the City of Edmonds has done.

III. THE DEMAND FOR BOARD AND CARE TYPE SETTINGS WILL CONTINUE TO INCREASE BECAUSE THEY ARE MORE ECONOMICAL THAN NURSING HOMES AND THE NUMBER OF OLDER PERSONS WHO CANNOT FUNCTION INDEPENDENTLY IS GROWING DRAMATICALLY.

It is widely acknowledged that board and care is a growth industry. A Congressional Subcommittee predicted continued rapid growth for several reasons: the relatively low cost of board and care compared to nursing home care or care provided in mental hospitals, and the continued growth of the frail elderly population. *Board and Care Homes in America: A National Tragedy, supra,* at 11-12. According to surveys, "among the elderly residing in board and care homes, about half the residents pay for their care with private resources." Hawes et al., *supra* note 2, at 51.[9] The other half are SSI recipients.[10] Hawes

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[9] SSI is the primary public funding source. In one survey, the reported sources of income were SSI (51.3 percent), Social Security Disability and regular Social Security benefits (50.8 percent), social services benefits (18.9 percent), private retirement, investment, or savings income (12 percent), earned income (10.7 percent), family contributions (8.5 percent), and Veterans Administration benefits (7.7 percent). Dittmar, *supra*, at 14.

[10] SSI, Title XVI of the Social Security Act, provides income support to persons aged 65 or older, blind or disabled adults and blind or disabled children, based on need. Disabled means any person

et al., *supra* note 2, at 54; Judith Feder et al., *Board and Care: Problem or Solution?, in Preserving Independence, Supporting Needs, supra,* at 27, 29. For the board and care residents who are SSI recipients, the costs of care will mirror the SSI benefit level. Dittmar, *supra,* at 14; Hawes et al., *supra,* at 57. The result is a cost efficient care model when compared to institutionalization.[11]

A trade association, the Assisted Living Facilities Association of America, concurs that the need for assisted living—another name for some kinds of board and care homes—will grow. The "unique combination of housing, personalized assistance, supportive services and health care will be in greater demand as more . . . families seek compassionate, low cost care in noninstitutional environments. As advocates for the elderly focus more attention on this long-term care option, it will grow in recognition, availability and acceptance." Coopers & Lybrand, *An Overview of the Assisted Living Industry* 22 (1993).[12]

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unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment expected to result in death or that has lasted or can be expected to last for a continuous period of at least 12 months. 42 U.S.C. § 1382c(a)(3)(A) (1988). Individuals are ineligible for SSI if they have resources in excess of $2,000. 42 U.S.C. § 1382(a)(3) (1988). The SSI payment is based on countable income, but an applicant must have little or no income to become eligible. The 1995 Federal monthly benefit rate for an individual is $458. Thirty-five percent of the nearly 6 million SSI recipients in 1994 were aged 65 or older. *Id.*

[11] The House Subcommittee reported the average per person cost for board and care to be $7,000 per year compared to $25,000 for a nursing home placement (1988 average) and $41,131 for a mental hospital (1987 average). *Board and Care Homes in America: A National Tragedy, supra,* at 11-12.

[12] Among the factors supporting future growth are greater acceptance of assisted living as a new alternative to institutionalization, conversion of nursing facilities to assisted living facilities, more private insurance, increased use of public funds for support in lieu of public support for nursing facility placement (i.e., increase in SSI rate or other federal support), increased life expectancy, and increased competition. Coopers & Lybrand, *supra,* at 22-23.

In addition to the economic advantages board and care provides over institutional settings, population growth trends predict a wave of older persons with disabilities. The older population needing access to new forms of residential services is increasing dramatically. The number of persons aged 65 and older is growing more rapidly than any other segment of the population. By 1989, one in eight persons was at least aged 65. *Aging America: Trends and Projections, supra,* at 2. By the year 2030, there will be proportionately more older persons than younger persons in the population—22 percent of the population will be aged 65 and older, while 21 percent will be under age 18. *Id.* at 8. Using conservative projections (hereinafter baseline projections),[13] the population aged 65 and older will grow from 32 million in 1990 to 41 million in 2010, an increase of nearly one-third in a 20-year span. Sheila R. Zedlewski et al., *The Needs of the Elderly in the 21st Century* II-7 (1989). The population is expected to reach 64 million by 2030, representing another 57 percent increase from the projected 2010 level. *Id.*

More importantly, those persons aged 65 and older with limitations in the activities of daily living will increase dramatically. In 1990, approximately 4.4 million persons of all those aged 65 and older had one or more limitations in the activities of daily living. *Aging America: Trends and Projections, supra,* at 144. By 2010, according to the Urban Institute's study, the number of persons aged 65 and older with ADL limitations will rise to 9.0 million under the baseline mortality scenario or to

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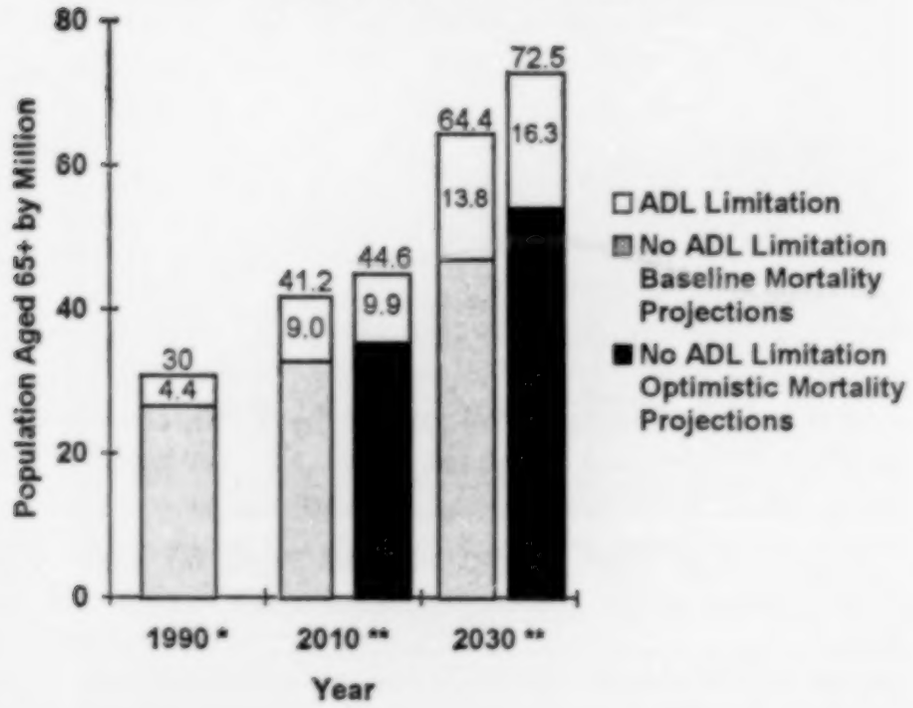
[13] The Urban Institute study cited herein as *The Needs of the Elderly in the 21st Century* at II-7 (1989) makes population growth projections based on two different assumptions about future mortality. The first is that the decline in death rates will slow to half its historical pace, and the second, more optimistic mortality assumption, is that the death rate will continue to decrease at its historical pace—a decline of 1.2 percent per year. *Id.* at ii. Using the first assumption therefore produces lower estimates of population growth which this brief refers to as the baseline projections.

9.9 million under the optimistic scenario. Zedlewski et al., *supra*, at II-34, Table 2.10. By 2030, the projections are 13.8 million persons (baseline) and 16.3 million persons (optimistic). *Id.*[14] These projections are illustrated in the following chart.

PROJECTED GROWTH IN POPULATION AGED 65+ WITH ADL LIMITATIONS



* Aging America: Trends & Projections at 144-45
** Zedlewski, supra, at II-7, II-34, Table 2.10

[14] The Urban Institute study projects that there will be between 8.7 (baseline) and 12 million (optimistic mortality) frail elderly (85 years and older) in 2030, compared with 2.5 million in 1984. Thus, in 2030 the population of frail elderly persons is expected to be 4.8 times the size of the same population in 1984, thereby greatly increasing the demand for community support services. *Id.* at ii-iii. The number of elderly persons at risk for long-term care services in 2010 is projected at between 9.1 (baseline) and 10.1 million persons (optimistic mortality), and likely will grow to between 13.8 (baseline) and 16.7 million persons (optimistic mortality) by 2030. *Id.* at vi.

The recent Urban Institute study starkly describes the rapidly changing face of the aging American population. By analyzing projected mortality rates, the anticipated prevalence of disability and consequent changes in living arrangements, and changes in income, the Institute report concluded that "the increase in demand for supportive services is likely to be greater than many realize because future increases in the number of frail elderly, elderly with health limitations, and elderly living alone will all exceed the general increase in the elderly population" and these factors will "be the major determinants of the future needs of the elderly." *Id.* at Abstract.

But growth in numbers is only one part of the picture. Social changes exacerbate the problem. "[A] much larger proportion of the elderly is likely to be living alone, and a larger proportion is likely to have some level of health dependency." *Id.* at II-42. Thus, when the health of older persons living alone deteriorates, there will be no family members to care for them. Even with additional in-home supportive services, there is likely to be a surge in the need for long-term care facilities of one kind or another. *Id.*[15] The statistics are staggering:

> Under the baseline projection assumptions, the number who will require some long-term care services rises to 9.2 million in 2010 and to 14.1 million in 2030. Thus, more than one in five elderly persons will require some services in 2010 and 2030 (the total number of elderly will be 41.2 million 2010, and 64.4 in 2030 . . .). Moreover, the number of elderly in institutions will rise to 3.0 million in 2010 and 4.3 million in 2030—an increase of 139 percent

[15] "Using the criteria that an elderly person living in the community with 2 or more limitations in incidental activities of daily living (IADLs) or 1 or more limitations in activities of daily living (ADLs) needs some formal, in-home services, these projections show that the demand for these services will rise dramatically—from 5.9 million elderly persons in 1990, to as many as 8.8 million elderly in 2010, and 14.7 million elderly in 2030." *Id.* at ix.

> over the 1990 projection. . . . [T]he number of elderly persons doubles during the same period. Thus, the need for long-term care services will increase faster than the size of the elderly population between 1990 and 2030, if the baseline mortality and health assumptions are correct.

Id. at IV-9. If the mortality rates do improve at historical levels and disability rates do not decrease, "16.7 million elderly will need long-term care services in 2030." *Id.* By either measure, there will be a population bulge of unprecedented dimensions. Some of these persons will need total care but numerous others will need less intensive assistance, the type of assistance provided in community-based group living arrangements.

CONCLUSION

The growth of the board and care industry demonstrates that, if given the opportunity, the housing market will respond to the projected growth of older persons with disabilities with a range of housing opportunities. The need exists now, and surely will increase. Free choice in housing will have little meaning to older persons with disabilities if restrictive zoning ordinances are used to prevent providers from opening new homes. The FHAA was designed to ensure the inclusion of all persons with disabilities into full community life by affording them equal housing choices and should be construed in light of that broad remedial goal.

For the foregoing reasons, the decision of the Ninth Circuit should be affirmed.

Respectfully submitted,

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